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District Health System/Primary Health Care: Updated Strategies and Approaches

Report of an Intercountry Consultation
Vellore, Tamil Nadu (India), 23-26 March 1999

World Health Organization
Regional Office for South-East Asia
New Delhi

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Community Health Cell
Library and Information Centre
359, "Srinivasa Nilaya"
Jakkasandra 1st Main,
1st Block, Koramangala,
BANGALORE - 560 034.
Ph : 2553 15 18 / 2552 5372
e-mail : chc@sochara.org

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1. INTRODUCTION

The results of the implementation of PHC approaches by Member Countries of WHO/SEAR have shown that providing health care services with equity, accessibility, emphasis on promotion and prevention, intersectoral action, community involvement, decentralization, integration of health programmes and coordination of vertical health programmes have not yet been totally achieved. Strengthening the capacity of mid-level personnel at district level is one of the keys to success as these people have to coordinate the top-down and the bottom-up management. There is thus a need to review the strategies and approaches undertaken by them. The emerging and re-emerging diseases affect health care management. Thus, the need to integrate health care services with more emphasis on child and adolescent health, women's health and reproductive health, quality essential health care and community health care financing. The development of human resources for district health system (DHS) has become widely accepted in terms of training orientation, career development and working conditions. Practical training with an exposure to other countries, experiences is one of the strategies to enhance the knowledge and improve the skills of district health managers.

The practical training on PHC at district level was started with the first round which was conducted in1995. The sixth and the last round was conducted in 1998. Thailand (ASEAN Institute for Health Development, Mahidol University), Indonesia (Directorate of Community Health Promotion in collaboration with the Centre for Education and Training of Health Personnel, Ministry of Health) and Sri Lanka (Ministry of Health in collaboration with National Institute of Health Sciences) were the host countries. Appropriate programmes based on study objectives are sometimes difficult to organize and execute. So the contents of the six rounds of practical training need to be revised in relation to changing situations. The total duration of the practical training was seven weeks (i.e. three weeks in Thailand; two weeks each in Indonesia and Sri Lanka). SEAR Member Countries were informed and nominations received at the WHO Regional Office. So far, altogether 131 participants from Member Countries have participated in this practical training.

The managerial aspects were also evaluated by participants. It was found that to make the practical training more efficient and effective, some of the managerial aspects need to be improved (i.e. communication among host countries and WHO; selection of participants; and VISA application procedure and preparation prior to departure from own countries).

2. SPECIFIC OBJECTIVES

(1) To critically review the experiences of six rounds of International Practical Training on PHC at District Level already conducted in Thailand, Sri Lanka and Indonesia;

(2) To develop guidelines for the revision of training curriculum in order to strengthen the integrated health care strategies and interventions;

(3) To develop guidelines for appropriate training methodologies; and

(4) To develop guidelines for field visits to identify: effective health referral systems; approaches to encourage community participation in health promotion, and appropriate approaches for the prevention of diseases.

3. DISTRICT HEALTH SYSTEM BASED ON PRIMARY HEALTH CARE IN SEAR COUNTRIES

The district health system is a more or less self-contained segment of the national health system which includes all institutions and individuals concerned with the improvement of health. It is also a coordination of component parts to provide a comprehensive range of promotive, preventive, curative and rehabilitative activities. DHS is a manageable unit of the health system which can integrate health programmes by adopting top-level and bottom-up planning, and is capable of coordinating government and private sector efforts. It can identify inequities and target them for action. Furthermore, it is the level at which joint intersectoral action is possible and community participation more feasible. The three main criteria used for defining the DHS unit for WHO/SEAR countries are: (1) a clearly-defined area with local administration and representation of different sectors and departments; (2) an area which can serve as a unit for decentralized

intersectoral planning of health care within the framework of local development; and (3) a health facility with inpatient referral support.

The administrative units which are equivalent to the district health system for WHO/SEAR countries are, namely Bangladesh – Thana; Bhutan – District; DPR Korea – County/District; India – Block; Indonesia – Kabupaten/ Kotamadya; Maldives – Atoll; Myanmar – Township; Nepal – District; Sri Lanka – Division, and Thailand – District. The strategies for DHS/PHC are to adopt national policies based on equity, to decentralize and develop local planning, to strengthen community involvement, to promote joint intersectoral action, to develop district leadership, to integrated programmes for sustainability, to link with referral hospitals and to mobilize and coordinate all possible resources.

4. ADDRESS BY THE REGIONAL DIRECTOR, WHO/SEAR

The keynote address by Dr Uton M. Rafei, Regional Director, WHO/SEAR, was read out by Dr Palitha Abeykoon, Acting WR, India. In his address, the Regional Director mentioned that PHC aims at the universal attainment of a level of health that will permit people to lead socially and economically productive lives and that the PHC approach embodies four mutually reinforcing principles, namely: universal accessibility and coverage of health care based on the needs of communities; community and individual involvement and self-reliance; intersectoral action for health, and appropriate technology and cost-effectiveness in relation to available resources. There are many unavoidable situations which affect health and development. Those are changes in demographic transition, changes in lifestyles, epidemiological pattern of diseases, double burden of communicable and noncommunicable diseases, the economic crisis in South-East Asia, inequity in health, the market-oriented approach and privatization of health care. Health care financing is another challenge for Member Countries.

WHO's critical role is to ensure that the moral imperatives of health for all and primary health care are understood to be able to help guide the formulation of different implementation strategies in countries of the Region. WHO will continue to advocate for a new health order under

which a health resources are allocated equitably and the best possible technical expertise provided to the countries.

5. INTEGRATED MANAGEMENT OF HEALTH CARE

Integration implies a rational and functioning referral system with specialists at secondary and tertiary levels. It is a process of bringing together common functions within and between organizations to solve common problems and developing a commitment to shared vision and goals and using common technologies and resources to achieve those goals. The benefit of integration lies in the development of more cost-effective strategies for the management of health services. Integration of activities and services if done carefully, opens up possibilities for the expanded use of existing facilities, better utilization of personnel, and improved patient satisfaction. Integration may improve the efficiency and effectiveness of health care delivery, but it is the only option for improving the performance of health services. The ultimate goal of integration is health for all through sustainable, accessible, and affordable quality health care.

Getting evidence of integrated health care strategies and interventions into policy, training and practice need to be encouraged. Engaging communities as partner in improving health outcomes should get more attention for district health system development.

6. LESSONS LEARNED FROM HOST COUNTRIES FROM 1995-1998

Practical training was started in Thailand in 1995. The contents of this training mainly comprised the PHC concept and strategies, and district health system management with the focus on intersectoral collaboration. In the last two rounds (1998), the subjects of health care reform and healthy cities were added. In Indonesia, the main emphasis was on integrated health post (Posyandu), and the role of women groups. Participants were exposed to health facilities at all levels. In 1998, practical training underwent a great change. It got directed to safe motherhood, reproductive health and health promotion. The innovative approach involving the "Social Safety Net" was also introduced. However, there was a slight change for Sri Lanka, as filariasis

control was deleted in 1997. The other vertical programmes remained the same i.e. malaria control, STD/AIDS control and MCH. Most of the topics presented to participants were function-based i.e. Public Health Nurse-Sister, Public Health Midwives, Public Health Inspector. The only community-based programme was rehabilitation. However, community participation was encouraged in other programmes too.

About the managerial aspects, the same related to course structure, participants' selection, participants' preparation before departure, logistics and the evolution process. All three components were made similar in the three host countries i.e. orientation/overview, field study and wrap-up discussion and presentation. In terms of participants' selection, it was found that there was a wide gap of background among participants ranging from the grass-roots level to the senior level such as under-secretary or regional director. There was no proper preparation of participants who participated in the practical training course as they had not been informed of the course. Thailand was the only country which provided information to participants but mostly it was not on time. Very often, there were problems in getting the VISA because of the short notice given to participants. However, logistically, there were less problems. In Thailand, it was difficult for participants to make an overseas call at the training institute. In Sri Lanka, the organizers were asked to provide an air-conditioned room for the meeting, but it was not available. Evaluation was done occasionally by all host countries i.e. session evaluation, daily reflection, field evaluation, wrap-up discussion for field observation, overall evaluation and programme evaluation by the organizing committee. A recommendation was made regarding the future selection of participants who should meet the requirements of English proficiency, professional level and good health.

7. PRESENTATION OF DISTRICT HEALTH SYSTEM/PRIMARY HEALTH CARE EXPERIENCES BY MEMBER COUNTRIES

7.1 India

The PHC activities for India are represented by the State of Kerala. Health of the people is the responsibility of the State Health Service (Directorate of Health) under the Directorates of Public Health, Family Welfare and Training.

The Ministry and Secretariat have the mandate for formulating health policies and providing budget and resources for the conduct of health programmes. Medical colleges at the tertiary level provide curative care at their teaching hospitals. At the district level, covering a population of 100 000, the Municipal Commissioner and the Collector for Cooperation represent the Ministry of Health with the main functions of administration, supervision and evaluation. The provision of health care services at this secondary level of care is the responsibility of district medical offices at district hospitals, *taluk* headquarters and private hospitals. The services range from 24-hours casualty services, basic health services, and emergency obstetric and newborn care. The primary health care services (preventive, promotive and basic curative care) are conducted at primary health centres, staffed with a medical officer and public health workers, and work closely with NGOs and the Social Welfare Department (ICDS).

The CHAD experience

CHAD is a programme of the Community Health Department, Christian Medical College, Vellore, Tamil Nadu. The Kanyambadi block, which CHAD first served, is an entirely rural area with a population of 80 000 living in 68 villages where 40% live below the official poverty line. At present, CHAD has expanded its service to Anaicut block with 130 000 population. Both the blocks serve as field laboratories for medical students as well.

In all programmes, CHAD works primarily with women and children who represent 70% of the population. The basic preventive services are totally free while hospital care is charged, based on the paying capacity. People from both blocks are identified by cards issued by CHAD and shown upon arrival at the CMC health centres or CMC hospitals. Health services are open to everyone and CHAD works closely with the government services in the provision of primary health care.

The primary level of care is provided in the form of three-tier services: at village level, by PTCHWS and health aides; at the second level, by mobile clinics staffed by public health nurses and doctors, and at the third level, by the secondary-level hospitals. The services range from antenatal and delivery care, immunization, TB and leprosy control programmes to nutrition monitoring. Fully aware that health is greatly influenced by social and

economic conditions, CHAD has extended its services to include training on income-generating activities for improving the economic and social status of families. Women are the main targets. For several years, these activities have been sustained. Furthermore, the income-generating units have been converted into independent societies such as CODES and SHARRE.

7.2 Indonesia

National health programmes on strengthening DHS based on PHC have been started with pilot studies being conducted in Bandung. In 1974, the sub-district health centre was first introduced as the primary level of care for a catchment area of 30-50 000 population. Activities performed at the health centre included: medical care, MCH, FP,CDC, nutrition, environmental health and sanitation, community health nursing, school health, mental health, simple laboratory service, health education and reporting/recording. The commitment of Indonesia to the Alma Ata Declaration for Health For All by the year 2000 is realized through the provision of primary health care services in a district health system with district hospital as the secondary level of care. At the village level, voluntary community health workers are organized under the PKK (women's movement) and together with village community midwives and health centre staff, the primary health care activities were rendered at the integrated health post (posyandu) established by community participation.

Indonesia has been one of the host countries for the past six rounds of international practical training in DHS based on PHC. The focal point was the DG for Community Health and training was conducted by the National Centre for Manpower Training. Other support teams comprised essential health programme managers, related NGOs, the Ministry of Interior Affairs, local governments and drug factories. Indonesia being a second country visited after Thailand, the focus of the training was on field experiences since the theory of DHS/PHC had already been discussed in Thailand.

The training centre claimed having improved the capacity in managing and handling international training after its experience of conducting six rounds. The constraints, among others, were the intensive workload of field preparation; extra workload of governmental facilities; extensive travel logistics, and the language problems of participants and field facilitators.

7.3 Maldives

Health facilities at the district level in Maldives are called "Atoll health centres" which provide inpatient care, treatment of general medical conditions including minor surgery, immunization, referral services at the island level and supervision of island health services. The island health services provide basic MCH services, prevention of communicable diseases, sanitation and hygiene, ARI and diarrhoea control, health education, and treatment of simple disease conditions. If there is any serious illness, the cases are referred to atoll health centres, the regional hospital or speciality care respectively.

The Institute of Health Sciences provides training in many categories i.e. a three-year training for Diploma in Nursing and Midwifery, PHC and MLT, a two-year training for community health workers, a one-year training in nursing aid, and a six-month training for family health workers, auxiliary nurse midwives and traditional birth attendants. Challenges for training are quality of training which too much content related to producing multipurpose workers and meeting demand of sector while maintaining quality; bringing new knowledge into training programmes; providing continuing education and getting adequate qualified candidates for the training programme.

7.4 Myanmar

The health programmes in Myanmar are administered under the Ministry of Health. At the state level, health care services are provided at comprehensive hospitals with a range of 12 disciplines; and hospitals providing four disciplines of health care are found at the district level. The Township Health Department is responsible for the provision of urban health care services, MCH, School Health programme, Communicable Disease Control and care at township hospitals with 25 beds. The rural health centres are headed by health assistants. Myanmar has various categories of voluntary health workers, namely CHWs, auxiliary midwives, TBAs and Ten Household Workers. Primary health care services at the grass-roots levels are provided by health centres together with NGOs, hospitals and clinics for traditional medicine. The Institute of Community Health, Myanmar conducts pre-service and in-service training for human resources in PHC. The pre-service training, which is spread over four years including four months of field practice, has an

enrolment of 100-120 students with 12 years of basic education per annum. Two tracks of in-service training are provided: the Regular Health Assistant and the Regular Supervisor Grade II programmes. Starting both training programmes have been taken over by the Division of Headquarters.

The in-service training comprises training programmes for Bachelor's degree in Community Health (two years); Condensed Health Assistant (three years); Public Health Supervisor Grade I (two years); Lady Health Visitor (nine months), and other needed refresher courses.

7.5 Nepal

Nepal has 75 districts but 58 district hospitals, 60 district health offices and 14 district public health offices. A total of 137 primary health care centres operate at the sub-district level. There also are 14 000 primary health care outreach clinics which provide minimum services such as IEC, counselling, family planning, safe motherhood, minor treatment, diarrhoeal control, nutrition education, ARI, STD/HIV-AIDS counselling, immunization and referral activities.

There are 46 584 female community health volunteers. There is one volunteer for each ward. The activities of community health volunteers include: MCH; diarrhoeal control; immunization; nutrition education including vitamin A distribution; hygiene/sanitation; healthy family and family planning; first aid; ARI, HIV/AIDS counselling; prevention of major communicable diseases; recording and reporting; assisting in outreach clinics, and coordinating the activities of mothers' group. The mothers' group mainly involves itself with the selection of community health volunteers and MCH activities.

7.6 Sri Lanka

Sri Lanka has a very good health infrastructure for the delivery of health care. The Primary Health Care complex forms the base of the three-tier system of health care available in Sri Lanka.

The PHC complex is formed by the Gramodaya Health Centre where regular field maternal and child welfare clinics, family planning clinics etc. are

conducted. The sub-divisional health centre is primarily an outdoor curative care facility with limited inward patient care services. An assistant medical officer or a registered medical officer or a qualified medical officer is in charge of these centres. A divisional level medical care institution is always manned by a medical officer, supported by one or two medical officers and a few assistant medical officers or registered medical officers.

Seventeen service components have been named by the Government of Sri Lanka under the PHC package, and the PHC team members have been identified to coordinate with Public Health Midwife, Public Health Inspector (PHI), Assistant Medical Officer/Registered Medical Officer and the Medical Officers in charge of small medical care institutions lying within the PHC complex. The Divisional Director, Health Services (DDHS) and Public Health Nursing Sister (PHNS) predominantly play managerial and supervisory roles besides providing health care services. A geographical area covering a population of about 60 000 is managed and administered by DDHS.

The PHC serves a population of nearly 3 000/5 000 and the PHI covers nearly 18 000-20 000 population. At present, there is only one PHNS in most DDHS areas and she has to supervise all the PHMH of the DDHS area.

NIHS was the focal point for conducting the PHC training programme.

Planning was jointly done by Deputy Director-General (Education, Training and Research), Ministry of Health, Director and staff of the National Institute of Health Sciences (NIHS) along with the relevant Directors of Special Units of the Ministry of Health. Guidelines provided by WHO were used in addition to the information gathered through discussions with selected trainees.

The health infrastructure, the primary and secondary functions of the PHC team members, the seventeen service components of PHC identified by the Government of Sri Lanka is provided by the PHC team members with available resources, the strength and loopholes or weaknesses of the PHC delivery system, service demands of the clients, how the service delivery and service demands have changed over the years and how it differs in different sectors, community involvement in PHC, intersecoral collaboration, NGO support, team effort needed for PHC service delivery etc. were demonstrated during field visits.

Only two days out of the 10-day programme were used for class room activities. The rest of the period was spent in the field set-up (within and outside the NIHS area).

Opportunities were provided to interact with the service providers, officers of other sectors, NGO community leaders, volunteers and clients.

Close monitoring and supervision of the programme was done by the coordinator with the assistance of the Deputy Director, Training and Field Services, NIHS and the Director, NIHS.

Feedback from participants and resource personnel was collected regularly and utilized for better structuring and organization of training activities.

7.7 Thailand

PHC in Thailand is aiming at people's self-reliance at all levels (i.e. individual, family and community). At the district level, there is a district health coordinating committee which comprises health staff from both district/community hospital and district health office. While the functions of district hospital are mainly curative, the district health office mainly plays the role of providing technical and supervisory support for PHC activities at sub-district and village levels. The main functions of a PHC officer are to develop human resources, to strengthen capacity of health staff for health problem management and to build up capacity of village health volunteers to manage CPHCC (Community Primary Health Care Centre). Now, PHC is being implemented nationwide through integrated health care.

AIHD (ASEAN Institute for Health Development) is the institute of Mahidol University. Its functions are teaching, doing research work and providing social services including training. For PHC activities, the Institute plays roles in capacity-building (e.g. training, technical support), research and development (e.g. model development, civil society, health sector reform) and being a resource centre (e.g. AIDS information centre, WHO collaborating centre, health education media). AIHD has been the focal point for practical training in Thailand for all six rounds. The efforts on changes of socioeconomic (e.g. politics, urbanized lifestyle), demographic and diseases

pattern (e.g. NCD, occupational disease) were added to the training contents of fifth and sixth rounds.

Health care delivery and referral system in Bangkok were presented to illustrate how it works in a city of 8.6 million population. There are approximately 120 hospitals and medical institutes providing medical services in Bangkok. With 60 health centres, 85 sub-health centres and 600 mini health centres, the referral system starts from cases referred from the mini health centres to health centres or sub-health centres and then to hospitals respectively. It is planned to be a two-way referral system. An effective referral system can help guarantee adequate medical care, and reduce waiting time, expenses, and hospital stay through a holistic approach, and improve the follow-up of activities.

8. DISCUSSIONS

During the meeting, discussions were initiated by on the concept of integration and how does integration work in reality. A full range of issues were identified which reflected the confusion regarding the meanings and definitions of integration as well as regarding its operationalization. The participants stressed the need for integration in health policy, programmes and research at all levels of DHS/PHC. It was noted that application of DHS based on PHC required supportive policies, attitudinal changes among health providers, greater understanding regarding integration as being more responsive towards the needs of people for health care, mainly women and children.

Participants were requested to review the six rounds of practical training on DHS/PHC and carefully analysed the contents and management constraints and problems faced by each host country.

Discussions on the Content and Managerial Aspects of the International Practical Training Course

An overview of the prevailing situation in their respective countries with regard to DHS based on PHC provides recognition that the application of the primary health care concept varies from country to country and therefore

determines the kind of health interventions. For example, Maldives with many islands needs to have strong primary health care units in each island in order to provide primary care before patients reach the hospital which sometime involves hours of transportation. Myanmar has various types of health providers in primary health care working on an *ad hoc* basis which raises the issue of human resource development plan.

Health manpower development was another aspect of the countries' presentations. Many countries highlighted the issue of the education of health manpower, especially the aspect related to the conflict between supply and demand. In Indonesia, the bachelor degree training course for health manpower is under the Ministry of Health. The curriculum has been designed as closely as possible to the tasks performed at the service level. In contrast, the medical education and graduate nursing schools are under the Higher Education of the Ministry of Education. It has rather rigid regulations and rules governing formal educational. The Consortium of Health Science is a body specially established to bridge the gap between supply and demand.

The drug supply and distribution system which facilitates primary health care service was demonstrated during the field visit to the district drug warehouse.

9. CONCEPTUAL FRAMEWORK AND CONTENTS OF DHS BASED ON PHC

9.1 PHC: Concepts and Approaches

- Concept reorientation
- Strategies used in challenging situations such as economic crisis, privatization of health care in public health facilities, and epidemiology of emerging and re-emerging diseases
- Appropriate technology in PHC approaches

9.2 Organization of Government Health Service at District Level

- District health system
- Intersectoral action
- Planning, implementation, monitoring and evaluation

9.3 Referral System

- Strategies (public health, clinical referral)
- Constraints

9.4 Integrated Management of Health Care

- Definition, concepts
- Feasibility of integration of health care programmes into health policies of countries
- Focus on disadvantaged groups, children, adolescents and women

9.5 Quality Essential Health Care

- Concepts
- Assessment of quality essential health care

9.6 Human Resources Development

- Assessment of capabilities of health personnel
- Career development e.g. in-service training, workshops, seminars

9.7 Financial and Logistical Management

- Financial planning and management
- Logistical management (maintenance and supplies)

9.8 Community Action/Involvement

- Partnership approach
- Sustainability of health development

9.9 Resources Mobilization

- Strategies
- Experiences from participating countries

9.10 Monitoring and Evaluation of the Implementation of Health Care Programme

- Definition
- Indicators
- Tool for monitoring and evaluation
- Target/standard set-up
- Systematic approach
- What to monitor and evaluate?
- Feedback

10. REVISED LEARNING OBJECTIVES OF PRACTICAL TRAINING

At the end of the training the participants should be able to:

(1) Critically review the PHC concepts, strategies and approaches in order to strengthen implementation in their country;

(2) Compare the organization of government health services at the District level;

(3) Define the integrated management of health care;

(4) Describe suitable forms of integrated management of health care for the following population groups and conditions:
   - Children
   - Adolescents
   - Men and women of reproductive age
   - The elderly
   - Displaced persons
   - People with disabilities
   - Chronic diseases
   - Emerging and re-emerging health problems (e.g. HIV/AIDS)
   - Groups with special needs
   - Disadvantaged groups

(5) Identify ways to strengthen the integrated health care management in DHS, based on information gathered from country experiences;

(6) Identify resource mobilization strategies for improving peoples' access to integrated care;

(7) Describe the quality of essential health care services which are relevant to the above and their country context;

(8) Assess the human, logistical, financial and physical resources for the implementation of quality essential health care services within their country context.

(9) Identify innovative approaches which will maximize intersectoral cooperation and community participation for health promotion, disease prevention, basic rehabilitation and curative care, and

(10) Identify strategies and tools for monitoring and evaluating the implementation of integrated health care management with the objective of improving DHS/PHC.

11. CRITERIA FOR HOST COUNTRIES

The criteria were set as follows:

(1) Political unrest should be seriously considered as a constraint.

(2) Cost of travelling should not be very expensive from each participating country to the three host countries.

(3) The training institute of each host country should have an experience in conducting international training and the areas of concentration should be based on PHC, Community Health Service, District Health System, and Health Management (not clinical-based).

(4) Host countries must present highlights of innovative strategies or approaches which function well in their own context, which they can share with other participating countries. Of course, challenges should also be revealed.

(5) Host countries should have enough number of qualified people to work both on technical and managerial aspects.

(6) It is not necessary that training institutes of host countries are WHO collaborating centres.

12. GUIDELINES REGARDING THE METHODOLOGY OF TRAINING

12.1 What to do?

- Secretariat Meeting
- Planning of lessons
- Course structure (plenary, field site, evaluation)
- Background of participants
- Advance circulation of information concerning country/district profile and some information needed from respective countries to participants.

12.2 Who will Facilitate the Training?

- As facilitators
- As resource persons
- English proficiency
- As interpreter in the field (people who know the local dialect as well as English language)
- Qualifications of facilitators/resource persons

12.3 Modules/Course Package

- Locally developed (as agreed) on lines of WHO/SEARO Training Manual on Strengthening Organization and Management of District Health Systems based on PHC, 1996
- Review of theories and concepts
- Easy study can be presented
- Individual country plan of action

12.4 Training Design/Approaches

- participatory manner
- problem-based learning
- based on adult learning process
- spend most of the time in field studies

12.5 Evaluation

- pre- and post-test for knowledge on some specific topics
- learning process
- quality of training
- managerial process (logistics, VISA, financial etc.)

12.6 Places of Training

- Places of training should be changed every two years in order to strengthen the training institutes of SEAR Member Countries.

13. GUIDELINES FOR FIELD VISIT

13.1 Contents of Field Visit

(1) Core field visit

- Based on district level (National/provincial briefing can be done in plenary using AV aids)

- No detailed paper; but the Fact sheet is needed
- Area to be covered
  - DHS
  - Integrated health care
  - Quality essential health package
  - Referral system
  - Intersectoral collaboration and community participation

(2) Specific

- Successful intervention in the field to improve PHC/DHS (Govt./NGOs)
- Lesson learned from country experiences (strengths and challenges)

13.2 Methodologies

- Objectives of field visits are clarified and noted by participants prior to setting off on a field visit
- Develop tool/checklist for observation with participants
- Wrap-up discussion – Report on lessons learned

13.3 Optimum Size of Group

- 8 – 10 persons

13.4 Preparation of Local Resource Persons

- Objectives of field visit are clarified
- Should facilitate discussion rather than do all the speaking
- Enable interaction between community/health personnel and other sectors
- Interpreters made available
- Willing to share limitations and problems
- Spot visits to be permitted

14. MANAGERIAL ASPECTS OF INTERNATIONAL PRACTICAL TRAINING ON DHS/PHC

The following is the checklist to be considered:

14.1 Selection of Participants

- Participants should be the district health or public health managers or assistants of DHS/PHC
- Participants should have sufficient knowledge of English to be able to participate in discussions and read and write the report
- Participants should be in good health and fit to make any required field trip

14.2 Visa

- Do they have visas for all three countries?
- Does the visa for each country cover the duration of entire training?
- Do they need visa for the country where they will be on transit on the way home?
- How can the host country facilitate participants to extend their visa? (in case the participants do not have visas for the second and third country?
- Costs of visa extension should be reimbursed by WHO.

14.3 Plane Ticket, Departure and Arrival

- Do participants have tickets for the next country?
- Do you have information on their arrival to your country and departure to the next country?
- Do you communicate with the next host country about the departure and arrival of participants to let them know ahead and arrange pick-ups?
- How about ticket confirmation?

14.4 Information

- Do host countries have information before hand about preparation needed to visit the country? e.g. weather condition, dress, country profile
- Do you seek information on food restrictions of participants
- Do participants have the address of your training institute and the name of the place for lodging as well as the telephone number?
- Do you keep other host countries informed about your detailed training sessions?
- Do you inform participants that WHO is not supposed to send learning materials back to their countries by WHO pouch?

14.5 Per Diem

- WHO country office will provide US$200 to each participant before leaving the country and keep the remaining 20%. Participants will get this 20% when they go back to their country and submit the report
- Participants will first get their per diem from the WHO country office in the first host country and the rest in the second host country. Totally, it will be no more than 80%
- Do they know the names of contact persons and telephone numbers?

15. CONCLUSIONS AND RECOMMENDATIONS

15.1 To Member Countries

(1) It should be recognized that not all programmes need to be integrated. What is working well need not be changed.

(2) Integration of programmes should not lead to health workers being overburdened.

(3) Systems should be developed for monitoring and evaluation of integrated programmes at district level as well as for evaluation of resources.

(4) Lessons learnt from the success and/or failure of integrated programmes should be carefully examined and shared.

(5) Training of health workers in PHC and integrated health care management should be reviewed and job descriptions revised accordingly.

(6) The referral system should be strengthened so that it functions properly.

(7) Public awareness of the different levels of health care referral system should be promoted.

(8) A mechanism should be developed for incorporating the new knowledge into training curricula.

(9) Efforts should be made to involve the community in the management of health care.

(10) The selection criteria for participants should be strengthened so that they are all at a similar level and are proficient in English.

(11) There should be different intercountry training courses on PHC for national managers and policy-makers, and district health managers.

(12) Staff below the level of a district health manager should not be included in the intercountry training.

(13) Training mechanisms need to be developed using a training of trainers approach so that participants are able to conduct training on District Health System Management.

(14) The training should be more specific and focused on: development of skills; transfer of knowledge; development of tools for management; incorporation of new knowledge and technologies, and monitoring and evaluation.

(15) Groups for field visits should be kept small so as to make it more beneficial to participants and less overcrowded for field workers and health facilities.

(16) Participants on field visits should respect the culture of the local people as well as their privacy.

15.2 To WHO

(1) A mechanism should be developed for follow-up of participants and how they are utilizing the knowledge and skills acquired in their country context.

(2) Future evaluations of intercountry training should include independent institutions.

(3) Each country should have the opportunity to host the training for two to three years. This would enhance the capacity of training institutions in each country to conduct training for DHS/PHC.

(4) WHO should clarify to all future participants of WHO intercountry consultations on DHS/PHC the process of selecting host countries which should be based on technical criteria.

(5) WHO intercountry consultations should include senior policy-makers from ministries of health of all countries.

16. ACKNOWLEDGEMENTS

The WHO Secretariat expresses its gratitude to Professor Abraham Joseph, Head, Community Health Department, Christian Medical College, Vellore and his colleagues who helped in the preparation and successful conduct of this Consultation.

Annex 1

PROGRAMME

Tuesday, 23 March 1999

0800	Registration
08:30-10:00	Inaugural Session
10:30-11:00	Integrated Health System and Community Health – Dr Hilary Homans, Special Adviser, Health System and Community Health Cluster, WHO/HQ
11:00-11:45	Practical Training on District Health System/ Primary Health Care – Dr Orapin Singhadej, Regional Adviser on Community Health Services, WHO/SEARO
11:45-12:30	Summary of contents and managerial process of former six rounds of the practical training in Thailand, Indonesia and Sri Lanka – Dr Nawarat Suwannapong, Short-term Consultant, WHO/SEARO
13:30-15:00	Country Presentation on Primary Health Care (15 minutes for each country/institution) Moderated by Dr Adik Wibowo, Short-term Consultant, WHO/SEARO – India – Maldives
15:30-16:30	Country Presentation on Primary Health Care (contd.) – Myanmar – Indonesia

Wednesday, 24 March 1999

08:00-08:15	Remarks by Dr Adik Wibowo
08:15-09:00	Country Presentation on Primary Health Care (contd.) – Thailand – Nepal – Sri Lanka
09:00-09:15	Guidelines for Group Discussion – Dr Orapin Singhadej
09:15-10:00	Group Discussion Group 1 – Conceptual framework Group 2 – Quality essential health care services at district level Group 3 – New directions for integrated health care strategies and interventions at district level
10:15-12:30	Group Discussion (contd.)
13:30-15:00	Group Discussion (contd.)
15:15-17:00	Plenary and review of training objectives

Thursday, 25 March 1999

08:30-17:00	Field Visit

Friday, 26 March 1999

08:00-08:15	Reflection
08:15-10:00	Group work Group 1 – Guidelines for training curriculum Group 2 – Guidelines for Field Visits

10:15-12:30	Group Presentation and Discussion
13:30-14:30	Rapporteurs of all Groups meet to develop recommendations from the Consultation
14:30-15:30	Report and Adoption of Conclusions and Recommendations
15:30-16:00	Closing Session

Annex 2

LIST OF PARTICIPANTS

INDIA

Dr Abraham Joseph
Professor & Head
Community Health Department
Christian Medical College
Vellore
Tamil Nadu

Dr Jaya Lalmohan
Principal
Health and Family Welfare Training Centre
Trivandrum
Kerala

INDONESIA

Dr I.G.P. Wiadnyana
Director
Directorate of Health Centre Development
Ministry of Health
Jakarta

Mrs Ni Ketut Adi Lisdiani SKM
Head
Health Training Centre (Bapelkes)
Denpasar
Bali

MALDIVES

Ms Husna Razee
Director-General
Institute of Health Sciences
Malé

MYANMAR

Dr Albert Aung Kyaw
Professor
Institute of Community Health
Yangon

Dr Khin Maung Pyone
Deputy Division Health Director
Mandalay Division

NEPAL

Dr Babu Ram Marasin
Medical Officer/Safe Motherhood Programme
Coordinator
Ministry of Health
Kathmandu

Dr (Mrs) Saroj Prasad
Chief of Nutrition Section
Child Health Division
Department of Health Services
Kathmandu

SRI LANKA

Dr S.A.P. Gnanissara
Deputy Director-General of Health Services
(Education, Training and Research)
Ministry of Health and Indigenous Medicine
Colombo

Dr (Mrs) S.D. de Silva
Director
National Institute of Health Sciences
Kalutara

THAILAND

Dr Patjuban Hemhongsa
Director
Office of the Primary Health Care
Ministry of Public Health
Bangkok

Dr Pantyp Ramasoota
Senior Adviser
ASEAN Institute of Health Development
Bangkok

Dr Wonchat Subhachaturas
Deputy Permanent Secretary
Bangkok Metropolitan Administration
Bangkok

OBSERVERS

Dr Sulochana Abraham
Professor of Community Medicine
Christian Medical College
Vellore
India

Dr Jayaprakash Muliyil
Professor of Community Medicine
Christian Medical College
Vellore
India

Mr M. Suryanarayana
Project Manager
ADRA "Community Based PHC Project" in
Nuzvid
Krishna District
Andhra Pradesh
India

Dr Suresh Ambwani
Senior Programme Officer
Danish International Development Agency
Royal Danish Embassy
New Delhi
India

WHO SECRETARIAT

Dr Orapin Singhadej
Regional Adviser on Community Health
Services
World Health Organization
Regional Office for South-East Asia
New Delhi
India

Dr Hilary Homans
Special Adviser
Health System and Community Health Cluster
World Health Organization
Geneva

Dr Nawarat Suwannapong*
Short-term Consultant
World Health Organization
Regional Office for South-East Asia
New Delhi
India
*(Department of Public Health Administration,
Faculty of Public Health, Mahidol University
Bangkok, Thailand)

Dr Adik Wibowo*
Short-term Consultant
World Health Organization
Regional Office for South-East Asia
New Delhi
India
*(Faculty of Public Health
Department of Public Health Policy &
Administration
University of Indonesia
Kampus U.I. Depok
Indonesia)

Ms Namita Pradhan
Technical Officer
District Health Systems
WHO-Indonesia
Jakarta

Annex 3

SUMMARY OF MANAGERIAL PROCESS OF SIX ROUNDS OF PRACTICAL TRAINING ON DHS/PHC (1995-1998) THAILAND, INDONESIA AND SRI LANKA

COURSE STRUCTURE

(Three components were made in all three countries i.e. Orientation/overview, field study and wrap-up discussion/presentation.)

Country	Orientation/ Overview	Field Study	Wrap-up Discussion/ Presentation	Total
Thailand	5 days	7 days	3 days*	3 weeks
Indonesia	2 days	7 days	2 days	2 weeks
Sri Lanka	2 days	7 days	½ day	2 weeks

*Action Plan formulation

PARTICIPANTS' SELECTION

Participants of different health backgrounds were recruited to this practical training which can be classified to roughly illustrate people who participated in the course as it was expected that it should be district health manager and his/her assistants.

Bangladesh : Mid- and senior-level and district health managers

Bhutan : District health manager

India : Mid- and senior-level from local government

Indonesia	:	Mid- and senior-level, district health manager and his/her assistant from both the training institute and the Ministry of Health
DPR Korea	:	Mid- and senior-level
Maldives	:	Grassroots, mid- and senior-level
Myanmar	:	Grassroots-level, district health manager and his/her assistant
Nepal	:	Senior level and district health manager
Sri Lanka	:	Grass-roots-level and district health manager
Thailand	:	Mid- and senior-level, all academic staff from both the training institute and the Ministry of Health

Participants' evaluation:

(1) Wide gap among participants

(2) Participants should not be older than 50 years.

(3) Language barrier, some participants cannot communicate in English (i.e. DPR Korea, Myanmar and Maldives) and some can communicate in English but cannot read and write (i.e. Sri Lanka)

PARTICIPANTS' PREPARATION BEFORE DEPARTURE FROM THEIR RESPECTIVE COUNTRIES

The authorized documents needed for getting VISA and plane ticket were provided to all participants by WHO. General information of Thailand which is one of the host countries and its training were provided to participants by AIHD (ASEAN Institute for Health Development) once the institute received the list of the participants.

Participants' evaluation:

(1) A short notice from the respective Ministry of Health

(2) Problems about getting VISA

- Long process

- Single VISA provided (some participants needing connecting flight had to stay overnight on the way home).
- VISA duration did not cover the entire training.
- Delay in getting VISA; so they arrived late by 2-3 days (sometimes by a week).

(3) Orientation prior to departure should be done by a responsible official of each country.

LOGISTICS

All administrative work was done by the secretariat for the training with the collaboration of people from WHO country office. The provision of logistics was flexible depending on the request of participants, as listed below:

	Thailand	Indonesia	Sri Lanka
Transportation:			
Airport pick up	Yes	Yes	Yes
Field Study	Yes	Yes	Yes
Sightseeing	Yes	Yes	Yes
Food:			
Arranged and self	Yes	Yes	Yes
Reception and cultural show	Yes	Yes	Yes
Accommodation: Arranged	Yes (dormitory & hotel)	Yes (hotel)	Yes (hotel)
Materials provided (bag, profiles, hand-outs, stationery)	Yes	Yes	Yes
Ticket confirmation	Yes	Yes	Yes
Validation of VISA	Yes	Yes	Yes
Meeting room facilities: Well-equipped	Yes	Yes	Yes

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WC 100
N99

Participants' evaluation:

(1) At AIHD, Thailand, it is difficult to make an overseas call.

(2) Sri Lanka should arrange for air-conditioning in the meeting room.

EVALUATION PROCESS

An evaluation was done occasionally by all three host countries. In Thailand, participants were asked to formulate action plan as a part of evaluation to see whether participants could apply what they learned/insight gained from the practical training or not. Action plans were drawn up by country teams with the help of guidelines which were given and explained at the very beginning of the training course. The other methods of evaluation are listed below:

	Thailand	Indonesia	Sri Lanka
1. Session evaluation	Yes	Nil	Yes
2. Daily reflection	Yes	Yes	Nil
3. Field evaluation	Yes	Yes	Yes
4. Wrap-up Discussion for field observations	Yes	Yes	Nil
5. Overall evaluation	Yes	Yes	Yes
6. Programme evaluation by the organizing committee	Yes	Yes	Yes

OTHERS

There are some aspects which need to be improved in order to make the practical training on DHS/PHC more effective. Major recommendations made by host countries are shown below:

(1) Communication among host countries, WHO country office and the WHO Regional Office should continue to improve as evidenced in each subsequent programme.

(2) The selection of participants should stress three requirements in order to have a more effective training programme:

- The proficiency level of English should be carefully maintained.
- The professional level of the nominated delegates should be no lower than district-level managers and their assistants.
- Participants should be in good health

(3) If possible, facilitators of the three host countries should have an opportunity to meet each other and plan together so that a linkage can be effected during the training.

Annex 4

SUMMARY OF CONTENTS OF SIX ROUNDS OF PRACTICAL TRAINING ON DHS/PHC (1995-1998) IN THAILAND, INDONESIA AND SRI LANKA

1. OBJECTIVES

1.1 Thailand

(1) To review the concepts and strategies of PHC.

(2) To enhance the knowledge of the participants on district health system management.

(3) To share Thailand's experiences in PHC implementation: both strengths and challenges.

(4) To provide an opportunity to participants to share their ideas and experiences on DHS/PHC.

1.2 Indonesia

(1) To improve the knowledge and experience of participants in the implementation of PHC at various levels of administration, including the referral support from the hospital.

(2) To enable participants to share experiences and enrich their knowledge and skills in PHC implementation for possible application in their respective countries.

1.3 Sri Lanka

(1) To study the health care delivery system in Sri Lanka in relation to PHC services and to compare it with those in other countries in the Region.

(2) To review the strengths and weaknesses in the methodology/strategies adopted for management of PHC at district level.

(3) To identify innovative approaches which will maximize intersectoral cooperation and community participation for health promotion.

(4) To observe the role of health volunteers in the delivery of PHC services.

2. COURSE CONTENT

2.1 Thailand

1995-1997	1998
Review PHC concepts and strategies	✓
BMN approach to QOL	✓
HFA Indicators	✓
PHC in a changing situation	Nil
District health system: structure and management	✓
Community needs assessment (rapid survey)	Nil
Planning and assessing health workers activities	Nil
Monitoring and evaluation	Nil
Management of quality assessment	Nil
–	Human resources for PHC development
–	Social mobilization
–	Health information system
–	Adapting PHC for the year 2000 and beyond

2.2 Indonesia

1995-1997	1998
Health policy and situation	Nil
District health system management	✓
Role of hospital/health center/village midwives/TBAs	Nil
Posyandu (Integrated Health Post)	Nil
Community participation/financing	Nil

1995-1997	1998
FP & EPI	Nil
Epidemiological surveillance	Nil
–	PHC in Indonesia
–	Safe motherhood
–	Mother-friendly hospital
–	CDC programme (TB, DHF, STD/HIV-AIDS)
–	Health promotion
–	PHC training
–	Drug supply for PHC
–	Social safety net

2.3 Sri Lanka (1995-1998)*

- Health care delivery system
- Malaria control
- Manpower training for PHC
- Urban PHC
- STD/AIDS control programme
- Regional training centre activities
- Intersectoral action for health
- Dental health programme
- Epidemiological surveillance and disease control
- MCH programme
- Role and function of PHC team
- Health education programme

* Filariasis control was deleted in1997 as part of the practical training on DHS/PHC.

3. FIELD STUDY

3.1 Thailand

1995-1997	1998
Health system management at provincial, district, sub-district level	✓
Intersectoral collaboration	✓
NGO & government collaboration in PHC	✓
Regional Training Centre for PHC	✓
HFA village	✓
Community PHC Centre	✓
Village drug fund/health volunteer	✓
Urban PHC	✓
–	Monitoring and evaluation process
–	Healthy city
–	Health care reform project

3.2 Field study in Indonesia

1995-1997	1998
Environmental and sanitation	✓
Role of family welfare movement (PKK)	✓
Role of women groups	✓
QA in drugs	Nil
Nursing school	✓
School health programme (little doctors)	✓

1995-1997	1998
Elderly club	Nil
Posyandu	✓
NGO working on FP, STD/HIV-AIDS	✓
Role of hospital and health centre	✓
Maternal health (Polindes)	✓
–	Mother-friendly movement
–	Mother-friendly hospital

3.3 Field study in Sri Lanka (1995-1998)

(1) Functions of PHC team
- Divisional Director of Health Team
- PHN sister
- PH midwives
- PH inspector

(2) Hospital
- General, district, rural, peripheral and maternity hospital

(3) Clinic
- FP, child welfare, nutrition
- Lactating women, pre-school children

(4) School dental services

(5) Provision of domiciliary care by PHC workers

(6) Food hygiene

(7) Community participation
- Village health volunteer
- Community-based rehabilitation

4. CONCLUSION OF PARTICIPANTS' EVALUATION ON CONTENTS

4.1 Thailand

(1) Overall contents and field study well accepted by the participants.

(2) More theoretical knowledge is needed, e.g. indicators for monitoring and evaluation, project planning.

(3) Repetition of contents for some sessions should be reduced, e.g. selection of village health volunteers (in PHC strategies, BMN approach and PHC development).

(4) Content on the management of 'health information system' is not clear.

(5) Some plenary sessions are broad and need to focus more on PHC, e.g. social mobilization.

Facilitation skills

(1) Plenary sessions at AIHD take the form, more or less, of lectures; they should be more participative.

(2) Some facilitators are not proficient in English.

(3) Translation at places where needed should be done immediately after presentation by the facilitator.

(4) Presentations during field study should not be very long. Instead, they should leave more time for discussions.

4.2 Participant's evaluation for Indonesia

(1) Overall contents and field study are well accepted by the participants.

(2) Repetition of visiting the places of similar settings, e.g. visit four health centers in one training.

(3) Most of the statistics presented during the field trip should be updated.

Facilitation skills

(1) Terminology in local language was used quite often which was difficult to understand.

(2) Some facilitators are not proficient in English.

(3) Translation should be done immediately after presentation by the facilitator.

(4) During field trip, facilitator should lead the discussion as sometimes the local resource person cannot get the point the participants want to learn.

4.3 Participant's evaluation for Sri Lanka

(1) Overall contents and field study are well accepted by participants.

(2) Most of the field visits are function-based; they should be more community-based, e.g. PHN sister, PHI, PH midwives.

(3) Most of statistics presented during the field trip should be updated.

Facilitation skills

(1) Facilitators are very fluent in English; however, they should speak slowly.

(2) Time was spent mostly on the bus during the field trip. Places to be visited should not be too far apart. Facilitators should be aware of this.

(3) There should be wrap-up discussions during the field study.